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MEDICAL CARE FOR THE AGED UNDER MAA and OAA

1960-64

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MEDICAL CARE FOR THE AGED

UNDER MEDICAL ASSISTANCE FOR THE AGED AND OLD-AGE ASSISTANCE

1960-64

MEDICAL CARE SERVICES for the needy aged under public assistance programs were extended considerably between 1960 and 1964 under the Kerr-Mills amendments to the Social Security Act passed in 1960. Four years experience in administering these provisions provides a basis for evaluating their effectiveness in meeting the medical care needs of elderly Americans when they are financially unable to do so themselves.

Public Law 86-778, including the Kerr-Mills amendments to the Social Security Act, (a) established a program of medical assistance for the aged (MAA), with Federal aid to the States for medical assistance to older persons not receiving old-age assistance but whose income and resources are insufficient to meet the cost of needed medical care; and(b) provided additional Federal aid to States for payments to suppliers of medical care under existing old-age assistance programs (OAA).

In September 1964, 36 States, the District of Columbia, Guam, Puerto Rico, and the Virgin Islands were making payments under medical assistance for the aged programs, and 3 States1/ planned to make such payments by the end of December. In addition, 30 jurisdictions had expanded or improved coverage or content of medical care services previously provided under old-age assistance programs, and 11 jurisdictions, which had not previously made such payments, were making direct payments to suppliers of medical care services under old-age assistance.

Direct payments to suppliers of medical care (vendor payments) increased 165 percent between fiscal years 1960 and 1964 for all federally aided public assistance programs. About three-fifths of the increased expenditures were for aged persons under MAA.

Provisions of MAA

Under MAA, the Federal Government shares with States in the total cost of the program; there is no limitation on either the individual payment or total State expenditures. The amount of Federal participation ranges from 50 to 80 percent of medical care expenditures paid to suppliers

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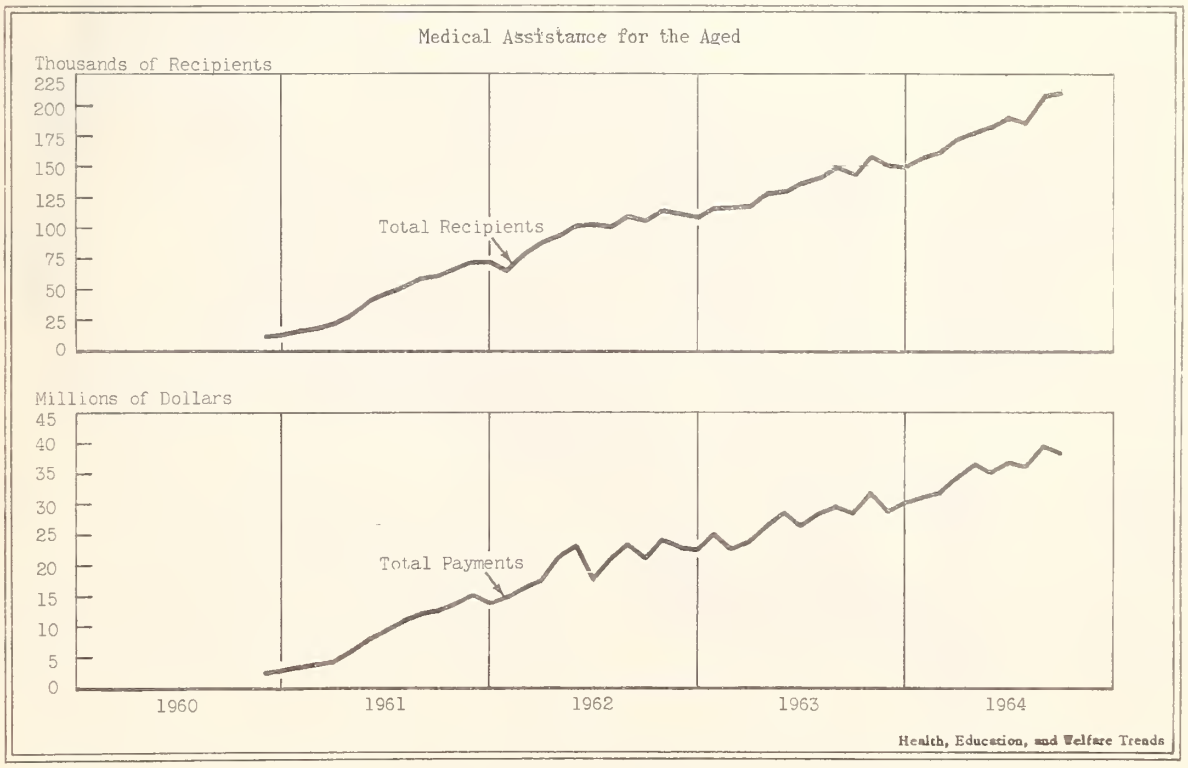
By Helen E. Martz. Dr. Martz is a social welfare adviser in the Bureau of Family Services. Data for 1964 are preliminary and subject to revision.
1/ Delaware, North Carolina, and Rhode Island.

of medical care in behalf of eligible recipients. The higher percentages go to States with lower per capita income.

States may make available a broad range of medical services. These include: (1) physicians', dental, private duty nursing, physical therapy and related services; (2) inpatient hospital, outpatient hospital or clinic, skilled nursing home, and home health care; (3) laboratory, X-ray, diagnostic, screening, and preventive services; (4) prescribed drugs and appliances including eyeglasses, dentures, and prosthetic devices; and (5) any other medical or remedial care recognized under State law. States determine the kinds and extent of services for which costs will be assumed and the conditions of eligibility for such services.

Relatively few conditions are imposed by the Federal act. Some of these are: (1) the State must include some institutional and some non-institutional care; (2) a durational residence requirement is not permitted; (3) no charge, such as an enrollment fee or premium, is permitted as a condition of eligibility; (4) a lien on account of medical assistance properly paid in his behalf may not be placed against the property of any individual prior to his death, and recovery of such assistance cannot be made except from his estate after the death of the surviving spouse, if any; and (5) disclosure of information concerning applicants and recipients is restricted to purposes directly connected with the administration of the program.

FIGURE 1



In addition to the usual share in old-age assistance payments, the Federal Government under 1961 legislation provides an additional amount based on expenditures for payments to suppliers of medical care up to a monthly maximum averaging $15 per recipient ($12 under the 1960 amendments). The additional funds were intended to enable States to improve or to initiate medical care services in their OAA programs. Amendments to the Social Security Act in 1962 increased from 50 to 75 percent the maximum amount of Federal financial participation that could be made available to States in the cost of rehabilitative and other social services, and provided also for Federal financial participation in the cost of vendor payments for medical care for up to 3 months prior to application.

Implementation of MAA

There were 208,354 recipients of MAA in September 1964 in 40 active programs (figure 1). They represented 15 per 1,000 persons aged 65 and over in these States and 12 per 1,000 of all the aged in the United States.

Table 1.--Total assistance payments for MAA, by source of funds, fiscal year 1964

State	Total expenditures (in thousands)		
	Total	Federal	State and local
Total.....	1/ $383,648	$196,461	1/ $187,187
Alabama.....	767	600	167
Arkansas.....	1,603	1,282	321
California.....	80,069	40,034	40,035
Connecticut.....	1/ 13,957	6,952	1/ 7,005
Dist. of Col....	1,714	857	857
Florida.....	1,402	851	551
Guam.....	15	8	8
Hawaii.....	1,657	828	829
Idaho.....	2,910	1,962	948
Illinois.....	5,160	2,580	2,580
Iowa.....	1,375	793	583
Kansas.....	1/ 1,446	792	1/ 654
Kentucky.....	2,108	1,585	523
Louisiana.....	984	723	261
Maine.....	1,307	858	449
Maryland.....	3,738	1,869	1,869
Massachusetts...	1/ 50,048	24,434	1/ 25,614
Michigan.....	22,142	11,067	11,074
Nebraska.....	40	22	18
New Hampshire...	589	332	257
New Jersey.....	1/ 11,043	5,465	1/ 5,578
New York.....	1/ 120,343	59,872	1/ 60,471
North Dakota....	1/ 2,670	1,930	1/ 740
Oklahoma.....	1,793	1,177	616
Oregon.....	5,865	2,933	2,933
Pennsylvania....	21,081	10,538	10,543
Puerto Rico.....	970	485	485
South Carolina..	1,984	1,587	397
South Dakota....	4	3	1
Tennessee.	2,065	1,560	505
Utah.....	2,959	1,836	1,123
Vermont.....	339	219	119
Virgin Islands..	26	13	13
Virginia.....	478	304	175
Washington.....	16,103	8,047	8,057
West Virginia...	2,842	2,040	803
Wyoming.....	53	26	26

1/ Includes money payments to recipients not subject to Federal matching: Conn.--$9,165; Kansas--$47,781; Mass.--$1,180,368; N. J.--$113,094; N. Y.--$598,533; N. Dak.--$27,268.

During the first 2 years of the program, nearly one-fourth of the approved cases had been transferred from other assistance programs, primarily in States that had large numbers of old-age assistance recipients requiring costly nursing home care and long-term hospital care. States in which the largest number of transfers occurred were California, Connecticut, Idaho, Massachusetts, Michigan, New York, and North Dakota.

From October 1, 1960, the effective date of MAA, through September 30, 1964, MAA payments for medical care totaled $1,026 million. Of this, $523 million, or 51 percent, came from Federal funds and $502 million from State and local funds.

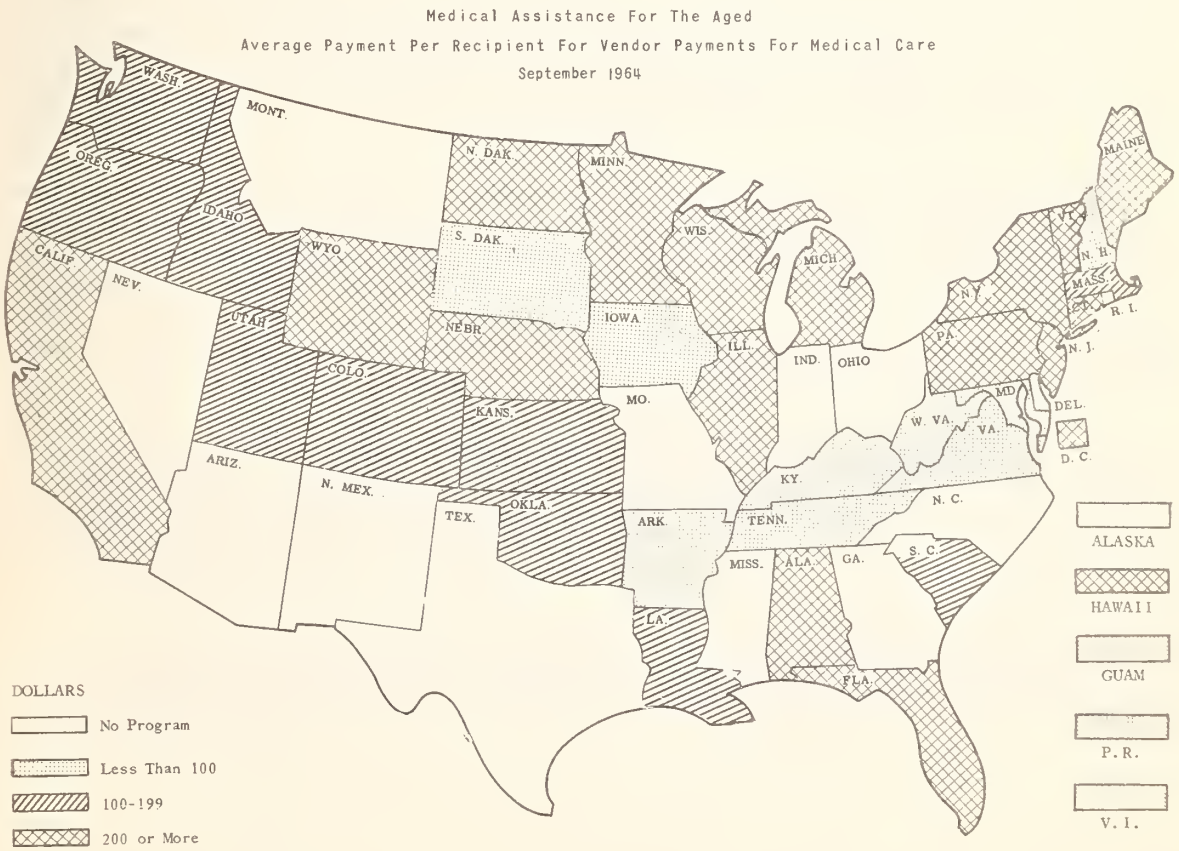
From the beginning of their MAA programs, California, Massachusetts, and New York have accounted for a relatively large proportion of total payments for all States. As additional States have initiated programs,

however, the proportion represented by these three States has declined despite continuing increases in their payments. In fiscal year 1962, the first full fiscal year for MAA, payments by these 3 States represented 81 percent of all MAA payments. This proportion dropped to 73 percent in fiscal 1963, and to 65 percent in fiscal 1964.

There is considerable range among the participating jurisdictions in the number of elderly persons receiving medical care under MAA and in the average payment per recipient. For example, in September 1964 the number aided ranged from 14 in Wyoming to 33,000 in New York. North Carolina had a program in operation but made no payments for medical care in September. Average MAA payments ranged from $22 in West Virginia to $376 in Florida. The average payment per recipient for all jurisdictions was $184. The high average payment areas were widely scattered throughout the country (figure 2). MAA expenditures in fiscal 1964 were $383,648,000 (table 1).

Most jurisdictions began their MAA programs conservatively. In September 1964, only 5 States (Hawaii, Massachusetts, Minnesota, New York, and North Dakota) provided for programs based on some care in each of the five major areas of medical services: physicians' services, dental care, hospitalization, nursing home care, and pharmaceutical services, without significant limitations on any service. Ten additional jurisdictions gave

FIGURE 2



some care in each of the major areas but with significant limitations on the condition for which care would be provided or the extent of such care, and 19 others provided three or four major services (13 included hospitalization, nursing home care, and practitioners' services) with some limitations on one or more of these. Six jurisdictions provided only the two services required by law--some institutional and some noninstitutional care. All 40 jurisdictions included some inpatient hospital care; 39, some physicians' services; 29, some nursing home care; 21, some dental care; and 24, some drugs.

About 42 percent of the expenditures made in MAA during fiscal 1964 were for hospitalization--a service provided in all jurisdictions with programs. While only two-thirds of the jurisdictions included nursing home care under their MAA programs, expenditures for nursing home care were higher than for hospital care. Hospital care and nursing home care costs combined accounted for 90 percent of total MAA expenditures; about 2 percent of expenditures were for physicians' services, 2 percent for prescribed drugs, and 5 percent for all other services.

Basis of Financial Eligibility for MAA

There is wide variation between States in methods of determining eligibility for MAA, and in amounts of income and other resources allowed. In more than half the jurisdictions with MAA programs, persons eligible for MAA who have health insurance or other potential resources covering services provided by MAA must use the resources before payment is made under MAA. Eight jurisdictions include a deductible feature--usually an amount which must have been obligated by an individual in a year for medical care before he can be eligible for MAA.

Most jurisdictions use a specified level of income in determining financial eligibility. In 14 jurisdictions, the income figure represents the amount considered as needed for living expenses, and income or available assets beyond that amount are evaluated against the cost of medical care received by the individual. The most common annual income level is $1,500; with $1,800 the next most common. The most liberal annual income level now being used by a State is $3,000 for a single person.

Thirty-nine of the 40 jurisdictions exclude life insurance from consideration as an asset under specified conditions, such as, in 20 jurisdictions, within a dollar maximum ranging from $500 to $3,000 with $1,000 the usual limit; and in 17 jurisdictions, within the dollar maximum for all personal property. Two jurisdictions exclude as a resource any value available from insurance.

All 40 jurisdictions take into account the availability of other personal property to meet medical care costs. In 39, there are dollar

limits on the amount that may be held without affecting eligibility. These range from $50 to $5,550, with most between $1,000 and $2,500.

All jurisdictions exempt real property used as a home, but 11 require that equity in the home not exceed a stated amount. Five jurisdictions do not allow holding real property other than the home, one permits it only if encumbered, and seven require it to be income-producing or developed into a resource that can be applied toward medical care costs. Some jurisdictions require the value of other real property in excess of certain limits to be applied to medical costs, and others specify limits on the value of such property which may be held.

Extended Medical Care Provisions Under OAA

All 54 jurisdictions made vendor payments for medical care services for OAA recipients in September 1964. Increased funds under the Kerr-Mills legislation enabled 11 jurisdictions which had no vendor payment programs for OAA recipients before September 1960 to incorporate such provisions. Thirty jurisdictions which already had vendor payment programs made their programs more comprehensive.

In fiscal 1963, 1.4 million OAA recipients--about half of all those who received OAA--received one or more types of medical or remedial care through vendor payments. The national average vendor payment for medical care per recipient of old-age assistance increased from $11 in September 1960 to $16 in September 1964 (this average is based on total caseload, including OAA recipients who did not receive medical care). Average vendor payments in the individual States for all OAA recipients ranged from a low of 34 cents in Montana (where only costs related to remedial eye care are met) and $1.07 in Puerto Rico to a high of $76 in Wisconsin. States with a high average vendor payment for medical care were largely concentrated in the northeast, north central, and the Pacific northwest areas. Averages were generally low in the southeast and the territories (figure 3).

By September 1964, 28 jurisdictions provided a relatively comprehensive scope of medical services in OAA. Eighteen States made vendor payments in each of the five major kinds of medical care (physicians' services, dental care, hospitalization, nursing home care, and pharmaceutical services), and 10 used the vendor payment method for four services and the money payment for a fifth service--nursing home care in 9 States and practitioners' services in one State.

Of the other 26 jurisdictions providing vendor medical care payments, 8 provided four of the major services; 5 provided hospital and nursing home care plus other physicians' services or prescribed drugs; 11 provided one or two of the major services, usually hospitalization; and 2 provided only nursing home care.

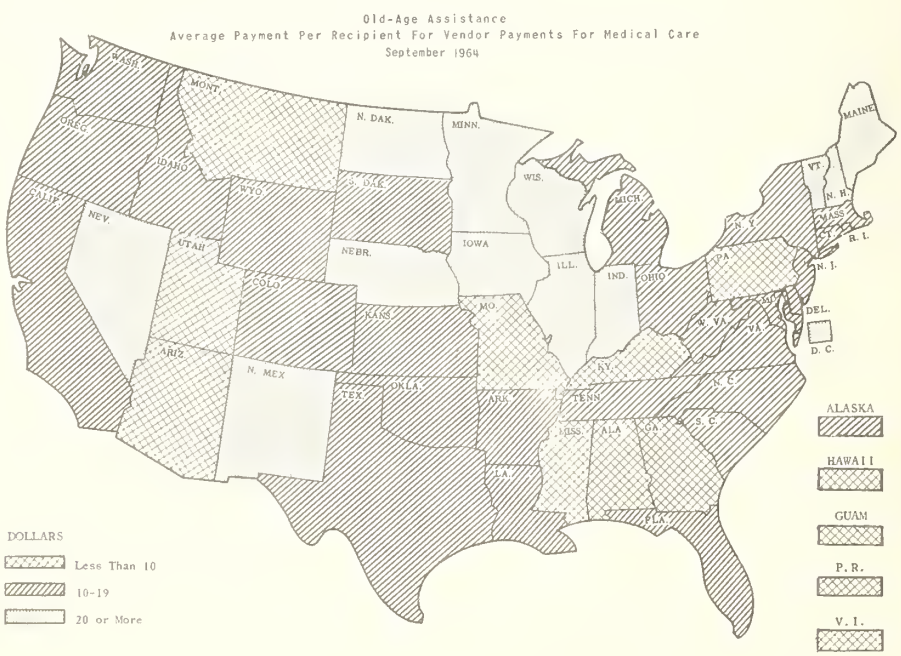
In fiscal 1963, more OAA recipients (roughly three-fourths) received physicians' services than any other type of care through vendor payments. Almost three-fifths received drugs, and almost one-third, hospital care.

Federal-State Cooperation

The 1960 legislation gave the Secretary of Health, Education, and Welfare responsibility for (1) developing and revising guides and recommended standards as to the level, content, and quality of medical care services for use by States in evaluating and improving their medical care provisions; (2) securing periodic reports from the States on items included in and the quality of medical care and services for which expenditures are made; and (3) publishing data secured from these reports and other information. These functions were delegated to the Bureau of Family Services in the Welfare Administration (formerly the Bureau of Public Assistance in the Social Security Administration).

To assist the States in the development of State legislation and other planning necessary to put the new medical care provisions into effect, a Division of Medical Care Standards was established in the Bureau of Family Services in 1961 with responsibility for developing guide materials and recommended standards, and for providing consultation to State public assistance agencies.

FIGURE 3



1/ Averages are based on all cases receiving assistance whether in the form of money payments alone, vendor payments for medical care, or both.

A medical advisory group, including physicians and specialists in paramedical areas, was also appointed to advise the Bureau on specific problems relating to medical needs and services to needy people. The medical advisory group usually meets twice a year to assist in the development of medical care guide materials and to make recommendations regarding policy areas with which the Bureau should concern itself in the promotion of improved medical service standards. In addition, consultants make factfinding and consultative trips to States in connection with administrative and program aspects of medical care, and a subcommittee advises the Bureau in the selection of medical care areas for special study. Three regional meetings have been held and additional meetings are being planned with the American Hospital Association to promote closer working relationships between staff of both agencies.

Guide materials and recommended standards prepared and issued by the Bureau of Family Services to help States expand and strengthen their medical care programs include such publications as "Financial Eligibility: Medical Assistance for the Aged"; "Casework Services in Public Assistance Medical Care"; "Reports on Cooperative Action Between State and Local Health and Welfare Agencies"; "Sketches on Working with the Sick and Disabled"; "Medical Care in Public Assistance, Organization and Administration"; "Home Health Care Services"; "Pharmaceutical Services"; "Dental Services"; and "Convalescent Leave from Mental Hospitals". An informational leaflet, "Medical Care for Older Persons", was prepared, and pertinent materials issued by other groups were distributed by the Bureau to States, including "Medical Assistance for the Aged and Nursing Services in the Home," prepared jointly by the Bureau and the Public Health Service and issued by the Public Health Service; "Your Nursing Services Today and Tomorrow," (Public Affairs Pamphlet No. 307); and "Guides for Drug Expenditures for Welfare Recipients," prepared jointly by the American Public Welfare Association and the American Medical Association. Other guides and recommended standards are being developed by the Bureau in such areas as physicians' services, optical services, hospital services, nursing home services, advisory committees, rehabilitation, and data collection and evaluation.

Several States are using federally approved optional administrative arrangements in the provision of medical care to recipients of MAA and OAA. Under these arrangements, States have contracted with other public or private organizations which are capable of providing certain managerial functions necessary in the administration of the program. The contractors in all but one such arrangement for MAA act as fiscal agents for the respective State welfare agencies.

For example, South Dakota is using an insurance-type arrangement with Blue Cross-Blue Shield. In Wisconsin, a commercial insurance company is being used as a fiscal agent. The lowest bidder was awarded the contract to perform specified managerial functions in the administration of the MAA program.

Administrative changes made in 1962 permit payment for psychiatric care in a general hospital for a period of 42 days for each episode, and provide assistance to persons conditionally released from mental hospitals to facilitate return to their home communities.

During the 4-year period, all jurisdictions gave legislative consideration to implementing the Kerr-Mills provision for MAA, and all but seven (Alaska, Arizona, Missouri, Montana, Nevada, Ohio, and Texas) enacted implementing legislation. 2/ In addition to the 40 jurisdictions that made MAA payments in September 1964, North Carolina, Rhode Island, and Delaware plan to make payments by the end of December 1964, and Indiana plans to begin a program in January 1965. Georgia, Mississippi, and New Mexico have not obtained funds to implement their legislation.

States have also increased their efforts to utilize more professionally qualified staff to carry their increasing responsibilities in medical care. Staff specifically identified with medical assistance and medical care activity increased gradually between 1950 and 1960 but has grown rapidly since then. Today, more than 20 jurisdictions have established full-time positions for physicians, many as medical care program directors. Most jurisdictions have one or more well-trained medical social workers on their staffs. Pharmacists are employed by some agencies, one State has a full-time dentist, and other paramedical personnel are also being used. All jurisdictions have medical advisory committees.

Meeting Medical Care Needs Under Public Assistance

Persons aged 65 and over make up 9.4 percent of the total population of the United States; their number is growing at the rate of about 1,000 a day. Their need for more health facilities and medical services is also increasing.

Since advancing age is accompanied by a decline in both physical and earning capacity, health problems and ability to pay for needed medical care are of major concern to the aged. Moreover, fewer older persons than younger persons are covered by health insurance, and those older persons who do have insurance often have less comprehensive coverage.

As described earlier, under the Kerr-Mills legislation, from September 1960 through September 1964, 30 jurisdictions extended their medical care provisions under old-age assistance, and 11 included vendor payments for medical services for the first time. The average monthly vendor payment

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2/ New Mexico already had necessary legislative authorization to include MAA and did not need to enact new legislation for this purpose.

per recipient under old-age assistance increased from $11 in September 1960 to $16 in September 1964. More of the medically needy aged are also being reached under newly established MAA programs--208,354 received MAA in 40 jurisdictions in September 1964. The average monthly payment was $184 for that month. Together, in fiscal 1963 the two programs of OAA and MAA provided some vendor medical care for about 1.7 million recipients, or 95 per 1,000 of the estimated population aged 65 and over.

Table 2. Vendor payments for medical care under public assistance programs

Federally aided program	Payments (dollars)	
	Total fiscal 1964 (millions)	Average per recipient September 1964 1/
All programs	1,044	--
Old-age assistance	421	16
Medical assistance for the aged	382	184
Aid to families with dependent children	123	3
Aid to the permanently and totally disabled	108	19
Aid to the blind	11	10

1/ The figure for the MAA program is based primarily on persons in whose behalf vendor payments for medical care were made in the month. The averages for the other programs are based on all cases receiving assistance whether in the form of money payments alone, vendor payments for medical care, or both.

Payments to suppliers of medical care for aged recipients of public assistance nearly tripled between October 1960 and September 1964. Of the total expenditure of $1,044 million in fiscal year 1964 for medical vendor payments under all the federally aided public assistance programs, $421 was expended under old-age assistance, and $382 million under medical assistance for the aged (table 2).

Yet even with this expansion, the extent to which States are reaching into the total group of medically indigent aged persons is limited. For example, about one-fifth of the total aged population reside in the jurisdictions which did not yet have MAA programs in operation in September 1964. The basis on which financial eligibility for MAA is determined by the different jurisdictions is only slightly higher than for OAA. Only five MAA programs provide some care in each of the five major areas of medical services without significant limitations on any of the services.

Although 77 percent of all vendor payments for medical care under Federal-State assistance programs were for aged recipients in fiscal 1964, the benefits of the MAA program are reaching a relatively small segment of the Nation's elderly, and this segment is concentrated in several States--over two-fifths of the MAA recipients resided in three States in September 1964, and nearly three-fifths (57.5 percent) of MAA expenditures were made by these three States. Variation between States remains wide.

The relatively limited State funds available to finance the costs of medical care, even with the liberal help of Federal grants under the Kerr-Mills legislation, has, of necessity, resulted in a variety of limitations similar to those utilized in the other public assistance programs--limits on income and resources, consideration of family responsibility, recovery provisions, and various eligibility conditions.

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Thus, 4 years' experience has pointed up both limitations and strengths of public assistance programs in attempting to meet medical care needs of the aged. As in all grant-in-aid assistance programs, the State has responsibility for initiating a program and for determining its coverage and the quantity and kind of care provided. The Federal Government provides technical consultation and encouragement and reviews State plan material to assure that a proposed program conforms to the Social Security Act. But the pace of development of the program is ultimately dependent upon State action, which in turn depends on availability of State funds and a willingness to use them for medical care needs in view of other demands for services.

The liberally drawn measure passed by Congress in 1960 has not yet realized its full potential largely because of lack of State financing and partly because of uncertainty about future costs. But it took 20 years for all States to establish programs of aid to families with dependent children, and 14 years after authorization of the aid to the permanently and totally disabled program, all States have not yet established such a program for their needy disabled.

MAA is just 4 years old. Despite fiscal and other problems, some States have made considerable progress in extending help to some of the needy aged in meeting their medical care needs. With time and experience, more States will probably extend their MAA programs, and others may establish new programs. But the cost factor continues to be an important consideration in making use of the full potentials of the Kerr-Mills legislation. With a backstop of social insurance for costly items of medical services such as hospital and nursing home care, MAA could undoubtedly enable States to meet more adequately other medical care needs of the aged.